The Nuffield courses were hailed as a milestone in the development of postgraduate medical education.[5] If their aim was to organize the organizers and nurture the embryonic vocational training schemes, it is the purpose of the MSD Foundation to nurture the College's quality initiative and raise the standards of general medical care. Time will reveal the effect of the courses on the present generation of young enthusiasts and on the future of general practice.

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Money and the nature of practice

THE way in which doctors are paid accounts in large part for the differences in general practice between countries in the rich world. The two systems which I know best are those which operate in the United Kingdom and in the Republic of Ireland. General practitioners in the Republic are paid a fee for each item of service; for almost 40% of the population the fee is paid by the state, the remainder of the population pay at the time, usually in cash. Because practice denominators are available only for the poorer 40% of the population, good data on consultation rates are restricted to this section of the population which over-represents the young, the old and the poor. Nonetheless the data demonstrate annual consultation rates twice as high as most figures from the UK, an average of over six per person per annum compared with three or even less in the UK. Domiciliary visits attract a larger fee and domiciliary visit to surgery consultation ratios are much higher than in the UK. Lastly, as might be predicted, doctors with small lists tend to have very high consultation rates.[1]

The Irish College of General Practitioners has recently made public a discussion document entitled *The future organisation of general practice in Ireland.*[2] For many years Irish general practitioners have looked enviously across the Irish Sea. Those things which they particularly envy are the security of UK general practitioners, their pensions and the 70% subsidy of staff salaries. General practice in Ireland is still predominately single-handed and poorly supported by secretaries, receptionists and nurses. Provision for his own illness, early death or retirement has to be secured (and often is not) out of the doctor's earnings. It is not surprising that the document wistfully compares Irish and UK practice and aspires to achieve what in the UK is commonplace. (Somebody remarked that the document is more about catching up than leaping over.) It addresses many other issues including teaching and training, continuing education and relationships with other health professionals, hospitals and specialists in community medicine. It touches on manpower planning.

The document also considers how practitioners in Ireland should best be paid. The suggestions refer only to the state funded sector, as no major change is envisaged for the remainder of the system. Not surprisingly it plumps for a scheme which would combine capitation and fee-for-item-of-service payments. Such a system still provides inducements for activity which discourage idleness and delegation but diminish the temptation to create unnecessary work.

I believe that governments on both sides of the Irish Sea and our two Colleges recognize, and have recognized for a long time, the importance of methods of payment in relation to standards of care. The tendency is for the two systems to come closer together. The Charter of 1966 and subsequent developments have concentrated on inducements on top of basic capitation.

It would, however, be nice if we eschewed euphemisms and talked more openly about self-interest. Money can be used constructively to improve the quality and alter the nature of practice for better.

This notion is implicit in both the College document *Quality in general practice* and the Government's green paper on primary health care.[3,4] Both speak of incentives, which is a kinder word than bribes, but neither has much to say about the distorting effects on practice of such payments. 'Special' payments induce activity but such activity can only be provided by diminishing the time and energy devoted to other things. For example, a practice which has demonstrably high levels of immunization, blood pressure recordings or cervical smears may have achieved these at the expense of listening to people or visiting them in their homes. Incentives, like Boadicea's chariot in reverse, cut both ways.

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Postnatal care — who cares?

BEFORE the birth of her baby a mother has probably been seen on about 9 to 12 occasions by her doctor and/or midwife to ensure that her pregnancy is progressing satisfactorily, and, as the carrier of the baby, she feels that she is the recipient of the attention. After a straightforward delivery, however, attention switches quite abruptly to the baby. Once she has been discharged by the midwife, the mother is offered just one routine check-up for herself at six weeks.

This six-week postnatal examination seems to be of a variable standard. Some mothers receive a full examination with a smear test, family planning advice and the opportunity to talk about any of their perceived problems affecting their health. In other

cases the woman is merely asked to stand sideways against a wall and is told she 'looks fine'.

This shift of emphasis from mother to baby occurs at a time when the mother is already coping with changes in the balance of her hormones and with a major life change which affects many areas including relationships with her partner and her own parents. Her own body image is radically altered. Combinations of these factors leave many women feeling abandoned, vulnerable and uncared for in the postnatal period. The sense of total responsibility for the dependent baby compounds these feelings.

There would appear to be two initial approaches which could help towards relieving this probem. First, the postnatal, six-week examination could be extended to allow time for the patient to express her own health-related needs, for these needs to be acknowledged and for her to be referred for specialist help when necessary. This applies especially to post-episiotomy problems, which many women feel are not fully understood by male general practitioners. A study of the health of women in the postnatal period carried out by the Early Parenthood Project at Cambridge[1] found a significant number of women were still suffering from tiredness, backache, depression, haemorrhoids and mastitis three months after the birth. These researchers suggest that there is considerable physical and psychological morbidity in new mothers during the first year of their babies' lives. They also suggest that these needs are not yet met successfully by those professionals most involved.

Recognition of this problem has lead the Health Visitors' Association to compile a postnatal 'checklist' which encourages mothers to identify any problems — physical, emotional or practical — before attending for their six-week check-up. By taking the list for reference it should enable them to ensure that these matters are discussed with their general practitioner. Perhaps general practitioners should consider offering a further check three months after the birth.

A second approach to the needs of new mothers is the setting-up of formal or informal support systems. Various self-help support groups are in existence both nationally and locally. For example, some branches of the National Childbirth Trust not only run antenatal classes and postnatal groups but also offer a personalized service. This involves introducing a named support person, herself a fairly new mother, so that each member of an antenatal class has contact with this supporter after the birth of her baby. The Meet-a-Mum Association (MAMA) grew out of Esther Rantzen's awareness of the problems of isolation and loneliness of new mothers. MAMA also runs local self-help and social groups in some areas.

These support groups are a valuable resource to new mothers for gaining information about other facilities for mothers and babies in the area. However, the effectiveness depends upon the commitment of members of the organization, and the support they receive from the professionals in their area. Health visitors themselves aim to put mothers in touch with the facilities in the area and are in an ideal position to initiate the setting-up of postnatal groups where these organizations do not already meet the needs of an area. Where health visitors are attached to a practice there would seem to be opportunities for both general practitioners and health visitors to be involved. Such a project is described by Nina Trick,[2] who stresses the need for the group to be a self-support group while emphasizing the importance of interest shown by the general practitioners and midwives in the group.

A study of formal and informal support systems in the Paddington and North Kensington area of London,[3] and a study by Clulow,[4] also support the view that the health visitor is in a prime position to assess the mothers' needs, initiate contacts and set up a group. However, Wood[3] concludes that the health visitor's role 'needs to be strongly supported by other professional groups who can participate and contribute in extending and facilitating the development of informal social networks within the community'. Other health visitors who have begun a support group for young mothers suffering from anxiety or depression have found the group extending to include mothers with other problems, such as a child with mental handicap.[5]

General practitioners have also played an active role in running parenting groups. One report cites a group initiated by health visitor contact but run by the general practitioner and psychiatric social worker.[6] Topics discussed included child development and management, the role of husbands, relationship with own parents, depression and loneliness, and death and bereavement.

With good cooperation between general practitioners, health visitors and others involved in primary health care it should be possible to develop groups appropriate to the needs of the area. Once initiated, such groups may extend themselves into support networks within the local community. As confidence grows the network could be extended to involve other isolated groups, for example, the elderly.

The improvements in antenatal care, neonatal care and child surveillance have had a dramatic impact on perinatal and infant mortality. For the new mother, however, social factors relating to health such as unemployment, marital breakdown and sequential families, housing problems, problems relating to ethnic background and teenage parenthood, can all add to the stresses of the neonatal period. As so many attendances at general practitioner's surgeries now have a stress-related base the importance of ensuring good physical and mental health in new mothers cannot be over-emphasized.

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